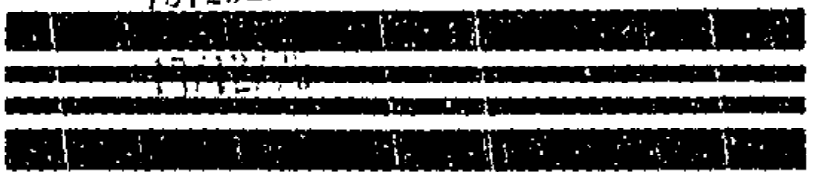
EXHIBIT P2

to COMPLAINT FOR INTERPLEADER

POLICY NUMBER: 958 201 834UM

10126201 3



OFFICE	2391
POLICY NUMBER	958 201 834
POLICY SUFFIX	UM
TRAN TYPE CD	52
TRAN SUB CD	6
INTERROGATOR	
INTERR SUB	
INT INITIALS	
ACCOUNT	N
INSURED NAME	LAMONT LOUDENSLAGER

ULA POLICY DATA SHEET

NEW ISSUE RUN DATE 10/[illegible]/1995

POLICY NUMBER	STATUS	PLAN	FACE AMOUNT	INSURANCE TYPE
958201834UM	W	FPMLI	100,000.00	L

POLICYHOLDER GENERAL INFORMATION

Policy Date............... 10/02/1995 SEX....(M) ISSUE AGE.... 41
Birthdate................. [redacted]/1954
Social Security........... [redacted]-4347
Policyholder Name......... LAMONT LOUDENSLAGER

Address Line 1............ [redacted]
Line 2............
Line 3............
Line 4............

Owner Name................ [redacted]
Address Line 1............
Line 2............
Line 3............
Line 4............

Res. State.....(016)
Iss. State.....(016)
Rstrct. Code...

POLICY MISCELLANEOUS INFORMATION

PLCMT Period Expiry Date.. 11/12/1995
Gen. User Area 1-2........ 913047531291347253334PASTOR LOUDENSLAGER
Gen. User Area 3-4........ LAMONT 0 0 A
Gen. User Area 5-6........ 1995/08/22 0004 0 N N 161 N 00111310
Gen. User Area 7-8........
Gen. User Area 9-10....... LAMONT LOUDENSLAGER
Gen. User Area 11-12...... S LOUDENSLAGER*KYM 2

ACCOUNT INFORMATION

Guideline Single
Premium................... [redacted]
Anticipated Annual
Premium................... [redacted]
Scheduled Premium.........

BILLING INFORMATION

Payment Mode........ (12)
Ownership Code...... (I)
Payment Method...... (P)

COMMISSION INFORMATION

		SPLIT %
Agency/Index.............. 859 4	District........... C11	% 100.0
Agency/Index..............	District...........	%
Agency/Index..............	District...........	%
Agency/Index..............	District...........	%
Agency/Index..............	District...........	%

INDIVIDUAL INSURANCE SEGMENTS

Special Class Code........ PN
Temp Flat Xtra.... End Date..
Reinsurance Type....
Company.............

RIDER AND BENEFIT GENERAL INFORMATION

Benefits attached.........

Riders Attached........... ADDL INS COVERAGE= 50,000 SEX=(F) CLASS=SN ISSU AGE= 38
CHILD COVERAGE= 5,000

ADDN.INS.NAME.......... LOUDENSLAGER KYM BIRTHDAY....07/31/1957 SSN0469-84-9352

FUND NO 001.... % 002.... [redacted]%003.... %004.... % 005.... %006.... %
007.... % 008.... [redacted]%009.... [redacted]%010.... 011.... 012....

CAAACS

_____ MVR
_____ T.I.
_____ OTHER

Case Assigned To: Shelly	Last Name / Ins #1: Loudenslager, LaMont	Age: 41
District / Agency	Spouse: Loudenslager, Kym	58
Bus Tel No / Home Tel No: 195 274 873	Call-up / Fee / Initials	

	Amount Applied	Additional	Alternate	Total New Ins	Ins In-Force Within Year	Total Within Year	Total Within 3 Month
Ins #1	100,000						
Spouse							

Information Outstanding — Insured #1

Req. Recd	Req Recd	Req. Recd	Req Recd	Req Recd
OO Exam	OO E.K.G.	OO APS	OO Tele Int	OO DO Reply
OO 2nd Ex	OO Ex Test	OO 2ND APS	OO Cons Rep	OO DO Reply
OO Re-exam	OO X-ray	OO 3RD APS	OO 2nd Rep	OO DO Reply
OO 1st Spec	OO SMA C	OO 4TH APS	OO 3rd Rep	OO
OO 2nd Spec	OO DES	OO MIB Details	OO Bus Rene	OO
OO 3rd Spec	OO BSAG	OO Prev. Apps	OO M V.R	OO Replac

Information Outstanding — Insured #2

Req. Recd	Req Recd	Req. Recd	Req Recd	Req Recd
OO Exam	OO E.K.G	OO APS	OO Tele Int	OO DO Reply
OO 2nd Ex	OO Ex Test	OO 2ND APS	OO Cons Rep	OO DO Reply
OO Re-exam	OO X-ray	OO 3RD APS	OO 2nd Rep	OO DO Reply
OO 1st Spec	OO SMA 12	OO 4TH APS	OO 3rd Rep	OO
OO 2nd Spec	OO HIV T4 T8	OO MIB Details	OO Bus Rene	OO
OO 3rd Spec	OO BSAG	OO Prev. Apps	OO M V.R	OO Replac

Limit
Table 1 Requires Income

Ins No 1	Spou
$ 55 K ok	$ OK? ok

CPI
LT
CIR
RENE
COM
MR

MORTALITY LIMITS BY AGE GROUPS
METROPOLITAN SERIES

AGES	PFD	ST	R1	R2	R3	R4	R5	R6
0-14	-	110	-	-	-	-	-	-
15-29	20	110	180	230	400	700	1200	1800
30-39	15	100	160	220	400	700	1200	1800
40-49	10	90	135	210	400	700	1200	1800
50 & OVER	10	86	125	205	400	700	1200	1800

Remarks | Medical Apps | T.I. Expires | 60-Day Pre-Expiry

Date	Name	Credit Obtained ☐ Yes ☐ No
8/30	de	[illegible] was[illegible] [illegible] [illegible]
		Please approve [illegible] OK
9/3	[illegible]	Please call agent, [illegible] phone #
9/11	TS	Repl[illegible] [illegible]

MEDICAL DECISION

	INS #1	SPOUSE
Pref / Stand / NR		
SRC	$	$
SRC	$	$
Aviation		
Avocation		
Driving		
Habits		
Medical History	+0	+0
Family History	+0	+0
Medical Findings		
Weight	+0	+0
B P		
B P Rx		
Urine		
Additive Factor		
TOTAL		
FEMALE CR	-20	-20
OCCUP	OK	OK
SMOKING	[redacted]	N
FINAL RATING		
Temp Years	$	$
Long Term	$	$

Underwriter

____ PHOTO CLERK, INCLUDE PAGE 2 ____ DECLINE DECLINE NUMBER ____

ALTER INITIAL INPUT DATA LAU ____ APPLICATION DISPOSITION DATE ____

1. Part A Date ____ 1a. French App. 1- Yes 2 No
2. Name ____ D O B ____ Age ____
3. Ins. Sex: 1-M 2-F 3a Ins Soc Sec No ____
4. Spouse/App ____ D.O.B ____ Age ____
4a Spouse/App Sex 1-M 2-F 4b Other Ins SS# ____
5. App Rel: 1 - Fa 2 - Mo 3 - Spse 4 - AV 5 - Un 6 - Grls 7 - Br 8 - Sis 9 - All Others
10 - No Applicant Designated
6. App Waiver Bene 1 - Yes 2 - No 6a Place ____ (App Signed)
7. Occupation ____
8. Certify ____ 8a PRI-Cn (SUB) ____ 8b Cnv ____
8c MIB Amb-1 Unit ____ 8d MIB Amb-2 Unit ____
9. Owner ____
Birth Year ____ Over 34C 1-Yes 2-No 3-No Own
9a. Owner Soc Sec No ____
10. Rel: 1 - Par 2 - Sp 3 - Au/Un 4 - Br/Sis 5 - Grp 6 - Trust 7 - Corp 8 - Part 9 - Sole Prop 10 - All Others
11 - No Owner Designated
11. Bill Add/Jav Own Add ____
____ 12. Billing State ____
13. Plan ____ OPT ____ 13a. Face Amount ____
13a-a. Mtg Ist Rate ____ 13b Dbl Waiver 1 - Yes 2 - No
14. FLIP PLAN. Qualified Plan ____
14a Type Plan 1-C 2-K 3-P 14b. New Plan ____
15. Opt Conv (Type) ____ 16. Fam Inc $ ____
17 ADB: 1-Yes 2-No 17a. GIR Act $ ____
18. Level Term. $ ____ 19. Spouse Inc Act $ ____
19a CVS Rider 1-Yes 2-No 19b. COL Rider 1-Yes 2-No
19c 10 YR Term $ ____ 19d. 1 YR Term $ ____
19e. Sp 10 YR Term $ ____ 19f. Sp 1 YR Term $ 50,000
19g Child Term $ 5000 19h. DOB of Old Child ____
19i. App ____

20. Ins. Class (1 - PFD) 2 - STD 3 - R1 4 - R2 5 - R3 6 - R4 7 - R5 8 - R6 SMOKER [redacted]

21 MODE: 1-A 2-S 3-Q 4-M (5-COM) 6-4A 7-NCB 8-Single 9-CONS 10-FESS 11-HOSS 12-Sal All 13-Pay Dec

22. Coupon No ____ 22a. Prev Amt Paid ____
22b Disclosure ____ 22c Suit Quer (All Aund Yes) ____ 22d Col(SUB) ____
22e Bill Day ____ 22f Trans No. ____
22g Bank ____
Account No
22h Depositor Name ____
23. DIVZ DIVZ DIVZ DIVZ DIVZ DIVZ DIVZ DIVZ DIVZ DIVZ
1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 ____
24. SMK INS: Cig Date ____ Nev ____ Cigar Date ____ Nev ____
Pipe Date ____ Nev ____ Tob Date ____ Nev ____
24a. SMK SP: Cig Date ____ Nev ____ Cigar Date ____ Nev ____
Pipe Date ____ Nev ____ Tob Date ____ Nev ____
25. Bene/Cont Own ____
Birth Yr ____ Over 34C 1-Yes 2-No 3-No Bene
26. Rel: 1 - Sp 2 - Children 3 - Par 4 - Br/Sis 5 - Au/Un 6 - Grp 7 - Est 8 - All Others 9 - No Cont Desgn
27 Agents Stat: 0-Lic 1-Div 2-Unlic 3-Lic Pend 8-No C & C
28. 1st Agent: DO ____ Det O ____ Agy ____ Ind ____
29 2nd Agent: DO ____ Agy ____ Ind ____ 2 ____
30 More than 2 Agts (UL only) see Misc ____ 30a I D Code ____
30b. Modal Prem ____ Plan Prem ____ 30c. Targ Prem ____
30d Resid Address ____
____ 30e Pol St ____ 30f Lag Lap ____
30g Dist. ID: (circle One No.)
1 = 90(1) 2 = 90(3)
30h. Emp Name: First ____ Last ____
30i. Pay No ____ 30j Pay Point ____
30k. (ast Pay Ded $ ____
30l. Deduct Date ____ 30m Freq ____
30n Employer Grp No ____ (FLIP or Mutual)

31. Ins At Appl ____ 44c. Date of Pol ____
32 Not Ins At Appl ____ 45. Error Skip 1 ____ 2 ____
Circle One 45a AIU/Add Pol ____ of ____
35 Medical - 1 46 Under I.D. ____
36 Nonmedical - (2) 47 Market Code ____
37 Paramedical - 3 47a Special Medical Code ____
38 Mutumatic - 4 (Decline only) 47b Agt - Lic ____
Amendment ____ 48 Reins Type ____ Co ____
40 Letter ____ 48a Dsib Ind ____
41 Amend Letter ____ 48b Sel Cls Ins $ ____ N ____
42 Alter Ist Input Date ____ 48c Sel Cls Spse $ ____ N ____
43 App of Add Date ____
44 Survey Code ____
44a Fixed Loan ____
44b. UL/UN Class ____

____ MIB
X NO REPORT

POLICY # 958201 73 4UM BATCH # 44515384

NAME SE DATE OCT 0 2 1995

REISSUE POLICY # ____ BATCH # ____

NAME ____ DATE ____

52 Blind Ins ____ Other ____
53 Ext Rider Avia ____ Other ____
54. Ins Ext. Prem Occ $ ____ Term ____ Avia $ ____ Term ____
T&R $ ____ Term ____ Temp $ ____ Term ____
55 R.S. End $ ____ $ ____ 56. Interim Term ____
57. ADB Rate 1 - 1 2 - 1 1/2 3 - 2 1/2 4 - 4
58. Partial ADE ____
59. Cnv Fund 1 - Same Dist 2 - Diff Dist 3 - Diff Terr
60. NFB: 1 - APL 2 - Red Paid-Up 3 - Extended Trm
61 Div Opt: 1 - Cash 2 - To Prem 3 - 1 Yr CV Max
____ 2nd Div Opt
4 - Acc at Int 5 - Paid Up 6 - Econ or COL

62. Prorate Billing Date ____
63 Spouse Med 1 - Med (2 - Nonmed) 3 - Paramed
64 Spouse Class 1 - PFD (2 - STD) 3 - R2 5 - R3 6 - R4
SMOKER ____ [redacted]
65. Spouse Bene Not Ins ____

66 Spouse SRC. Occ $ ____ Avia $ ____ T & R $ ____
Temp $ ____ Term ____
67. Tax Status (Not TR) ____
68. Max Code ____ Yr Limit ____ Yr Opt ____
69. R.R.S.P. Name ____

____ Form Letter 0843-A Para ____ ____ Amendment
____ Form Letter 01743 Para ____ 0843-82 Para ____

____ POLICY EXCHANGE ____
KS ✓ REPLACEMENT - 30 DAY FREE LOOK ____

SUITABILITY OK [signature]
MISCELLANEOUS ✓ PLACE OF SIGNATURE OK ✓
____ FAMILY GROUP ____ SEND LETTER
X BENE OK

Amend Beneficiary [illegible]
[illegible]

Amend Cont. Bene to: ____
Amend the [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

101348377 -4

8. Occupation

(a.) Occupation of Proposed Insured - Job Title and Duties: PASTOR

(b.) Employed by: FIRST BAPTIST — How Long? 5 YR

(c.) Actively at Work? (If a homemaker, are you performing regular household duties; if a student, are you attending school regularly? If No, attach explanatory letter.) Yes ☒ No ☐

9. Tobacco Use

Indicate date Proposed Insured last smoked/used

cigarette | cigar | pipe | smokeless tobacco

[redacted]

10. Attending Physician

(a.) Name and address of personal physician, practitioner or health facility used by Proposed Insured [redacted]

(b.) Date of last consultation [redacted]

(c.) Reason for consultation and diagnosis, treatment and advice

ITEMS 11 AND 12 APPLY TO AND ARE TO BE COMPLETED FOR ALL PERSONS TO BE INSURED.

11. Medical Data

For any Yes answers, give details below.

Has any person proposed for insurance

(a.) In the last five years, been treated, examined, or advised by any physician, practitioner, or health facility? (Do not include colds, minor viruses or minor injuries which prevented normal activities for a period less than 5 days.)

(b.) Ever received treatment, attention, or advice from any physician, practitioner, or health facility for, or been told by any physician, practitioner, or health facility that such person had heart trouble, chest pain, high blood pressure, diabetes, lung disease, tumor, or cancer?

(c.) In the last two years, had persistent cough, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, swollen glands, patches in mouth, visual disturbance or recurring diarrhea, fever, or infection?

(d.) In the last five years, received or applied for disability or hospitalization benefits from any source?

(e.) Ever had any surgical operation not revealed in previous questions or gone to a hospital, clinic, dispensary, or sanitarium for observation, examination or treatment not revealed in previous questions?

(f.) Had a parent, brother, or sister with heart or coronary artery disease, high blood pressure, cancer or diabetes? (If Yes, give details for each person, including age at onset and age at death if applicable.)

[redacted]

Details

Item No	Name of Person	Name and Address of Each Physician, Practitioner and Health Facility	Dates and Durations	Nature and Severity of Condition, Frequency of Attacks, Specific Diagnosis and Treatment

Details for Yes answers to Items (d.) and (f.)

101348377 -3

MetLife

X Metropolitan Life Insurance Company
☐ Metropolitan Insurance and Annuity Company

10/2/2015 1

PART A — APPLICATION FOR LIFE INSURANCE

1. Identity of Proposed Insured

LAMONT LOUDENSLAGER — M — MARRIED — [redacted]-54
Full Name First, Middle Initial, Last Name — Sex — Marital Status — Date of Birth Mo /Day/Yr.

SD USA — 5'10" — 165 — 88,000 — [redacted]-4347
State/Country of Birth — Co. Use Enter Age Last Birthday — Height Ft. In. — Weight Pounds — Total Life Insurance in all companies (including Metropolitan) — Social Security Number

2. Address

[redacted]
Mailing Address of Proposed Insured, or Owner if named in Item 6. Number, Street, City or Town, State and Zip Code

3. Plan

(a.) PLAN (For VLI or FPMLI Complete Supplement II to Part A): FPMLI

(b.) AMOUNT (The Specified Face Amount or Guaranteed Insurance Amount): $ 100,000

(c.) COMPLETE FOR UNIVERSAL LIFE PLANS

I. Death Benefit Option (check one)
- ☒ Option A (Specified Face Amount)
- ☐ Option B (Specified Face Amount PLUS the accumulation fund or cash value)

II. Planned Premium Amount [redacted]

(d.) For a qualified Plan specify:
I. Type of Plan
- ☐ II. New Plan
- ☐ III. Existing Plan- Employer Group No.

(e.) State any Special Request

4. Optional Benefits

☐ Disability Waiver	☐ 1 Year Cost of Living	☐ 10 Year Term $	☐ Guarantee Issue: Option Amount
☐ Accidental Death	☐ 1 Year Term $	☐ 20 Year Family Income $	$

5. Premium Payments

(a.) Select a mode of payment which is available with the plan applied for:
☐ Annual ☒ C-O-M ☐ Govt. Allot.-Mil. ☐ Govt. Allot.-Civ. ☐ Sal. Sav. ☐

(b.) Amount paid with application: [redacted] ☐ None This Amount ☒ is ☐ is not at least equal to one C-O-M premium

6. Owner/ Contingent Owner

(a.) Owner if other than Proposed Insured (Full Name of person or firm) — Relationship to Proposed Insured — Date of Birth — Social Security # or Tax I.D. #

(b.) Contingent Owner (Full Name) — Relationship to Proposed Insured — Date of Birth — Social Security # or Tax I.D. #

(c.) ☐ Check here if Proposed Insured is to become the Owner if pre-deceased by both the Owner and Contingent Owner, if any, indicated above (only applicable if Proposed Insured is age 15 or over)

7. Beneficiary/ Contingent Beneficiary

(a.) Revocable Beneficiary (Full Name): KYM LOUDENSLAGER — SPOUSE — [redacted]-57
Relationship to Proposed Insured — Date of Birth

(b.) Revocable Contingent Beneficiary (Full Name) — Relationship to Proposed Insured — Date of Birth

(c.) ☐ Check here if all present and future children born of the marriage of Proposed Insured and current spouse are to be included as contingent beneficiaries.

(d.) Address of Beneficiary or Contingent Beneficiary, if different from address in Item 2.

NOTE: (i) Unless indicated otherwise, if more than one beneficiary is alive when the insured dies, we will pay them in equal shares. If no beneficiary is alive when the insured dies, the contingent beneficiary will become the beneficiary. (ii) Any entry in Item 7 is invalid for a Corporate Pension or Profit-Sharing Plan or Public Employee Deferred Compensation Plan. (iii) A check in Item 7(c.) above is valid only if the proposed insured's current spouse is named as the beneficiary.

101348377 -6

Agreement

I have read this application and agree that all statements and answers are true and complete to the best of my knowledge and belief. It is also agreed that:

1. The statements and answers in Part A and if applicable Supplements I and II to Part A, Part B and the Aviation and/or Avocation Questionnaire, are the basis of any policy issued.

2. No sales representative or other person except the President, Secretary or a Vice-President of Metropolitan may (a) make or change any contract of insurance, or (b) make any binding promises about insurance benefits; or (c) change or waive any of the terms of an application, receipt or policy.

3. No information about any person to be insured will be considered to have been given to Metropolitan unless it is stated in this application.

4. Except as set forth in the Receipt and Temporary Insurance Agreement, Metropolitan will have no liability until a policy is delivered personally to the owner and the full first premium due is paid. The policy will then be in effect as of its date of issue. But it will not be in effect unless at the time it is delivered

(a) the condition of health of each person to be insured, and of the applicant if the Applicant's Waiver of Premiums Benefit is applied for, is the same as given in the application;

and

(b) no person to be insured, nor the Applicant if the Applicant's Waiver of Premiums Benefit is applied for, has received any medical advice or treatment from a physician or other practitioner since the date of the application.

5. If any annual dividends are payable on a policy issued under this application, they may be taken in cash or used in any other way provided by the policy. A choice may be made by an entry in Item 3(e). If there is no such entry, annual dividends will be: (a) left with Metropolitan to earn interest if the policy is a Term Plan or if Item 3(d) is checked, or (b) used to buy paid-up additional insurance if the policy is a Life plan and Item 3(d) is not checked; or (c) used as stated in the policy applied for.

If dividends are left with Metropolitan to earn interest and Item 3(a) is not checked, the owner certifies, under penalty of perjury, that the owner's Social Security or Tax I.D. number shown in Item 1 or 6(a) is correct and the owner

☐ is
☒ is not **subject to a backup withholding order issued by the IRS.**

WITNESS (Licensed Representative)	PLACE (City/State where signed)	Mo Day Yr	SIGNATURE
D A	LORRAINE, KS	6/12/95	(A) Proposed Insured (Age 15 or Over)

Witness to Signature in (A)

Br/Dist. No C-11 Agency 859 Ext. 4

D A	LORRAINE, KS	6/12/95	(B) Other Proposed Insured

Witness to Signature in (B)

Witness to Signature in (C) or (D)

(C) Owner (if named in Item 6)

If Owner is a firm or corporation, other than (C) for business of the kind appears on Item 6, and have a partner or officer (other than Proposed Insured) sign on line (D) and give title

(D)

Signature Title

Complete this only for a Juvenile Policy. Also be sure to complete Part 6 and have Owner sign in (C) above

Witness to Signature in (E)

(E) Applicant (Juvenile Policy)

Witness to Signature (F)

(F) Child (required only if a New York State resident and exact age is between 14½ and 15)

Also to be signed below if Applicant or Owner is not a parent, guardian or person liable for child's support.
I consent to this application for insurance on the life of the Proposed Insured. I have read the answers in this application, and they are true and complete to the best of my knowledge and belief.

Witness to Signature in (G)

(G) Parent, Guardian or Person Liable for Child's Support

101348377 -5

12. Non-Medical Data

For any Yes answers to items (a.) through (f.), give details below.

Has any person proposed for insurance

(a.) Ever had an application for Life or Health insurance declined, postponed, rated, modified or required an extra premium?

(b.) Any other application for Life or Health insurance now pending or planned in this or any other company?

(c.) Intentions in connection with the policy applied for, to borrow against, surrender or discontinue existing insurance or annuities (including Group) in force with this or any other insurer?

(d.) Had a driving license suspended or revoked in the last 3 years; or been convicted of 3 or more moving violations in the last 3 years; or ever been convicted of driving while impaired or intoxicated?

(e.) Been outside the U.S. or Canada in the past 2 years, or intend to be in the next 12 months?

(f.) Ever used heroin, cocaine, barbiturates or other drugs, except as prescribed by a physician or other licensed practitioner; or received treatment or advice from a physician or other practitioner regarding the use of alcohol, or the use of drugs except for medical purposes; or received treatment or advice from an organization which assists those who have an alcohol or drug problem?

(g.) Flown as a pilot, student pilot, crew member or passenger (except on a scheduled airline) in the last 2 years or intend to do so in the next 12 months? If Yes, complete the Aviation Questionnaire.

(h.) Engaged in, or plan to engage in Automotive, Motorcycle or Power Boat Sports; Bobsledding; Ballooning; Scuba or Sky Diving; Hang Gliding (including Slope Soaring, Para-kiting, etc.); Mountain Climbing; Parachuting, Snowmobile Racing or any other hazardous sport or hobby? If Yes, complete the Aviation Questionnaire.

[redacted]

Details

Item #

Driver's License Data

In ALL cases, give name, driver's license number and state of issue for each person to be insured.

LAMONT A. LOUDENSLAGER [redacted] ND

101348377-8

DO NOT WRITE HERE

101348377 -7

SUPPLEMENT I TO PART A
Other Persons to be Insured by Riders

1. Identity of other Persons to be Insured 101232045 5

Full First Name, Middle Initial, Last Name	Sex	Relationship to Proposed Insured	Date of Birth Mo./Day/Yr.	State/ Country of Birth	Co. Use Enter Age Last Birthday	Height Ft. In.	Weight Pounds	Total Life Insurance in all companies (Including Metropolitan)	Social Security Number
KYM	F	Spouse	[redacted]57	MN/USA		5' 3"	110	50,000	[redacted]9352
KALAE	F	daughter	[redacted]90	KS/USA	5	3'10"	55	4,000	[redacted]3647

2. Benefits (if available with the plan applied for)
- ☐ Income Benefit on Insured Spouse $
- ☐ Spouse 10 Year Term Rider $
- ☐ Applicant's Waiver of Premiums Benefit (AWB) (Include applicants name in Item 1. above.)
- ☒ Spouse 1 Year Term Rider $ 50,000
- ☒ Children's Term $ 5,000 (Enter the names of all eligible children in Item 1. above.)

3. Occupation of Spouse or Applicant for AWB
(a.) Job Title and Duties HOMEMAKER
(b.) Employed by How Long 17 YRS
(c.) Actively at work? (If a homemaker are you performing regular household duties? If a student, are you attending school regularly? If No, attach explanatory letter.) Yes ☒ No ☐

4. Tobacco Use
Indicate date Spouse or Applicant for AWB last smoked/used:
cigarette cigar pipe smokeless tobacco
[redacted]

5. Attending Physician
(a.) Name and address of personal physician, practitioner or health facility used by Spouse or Applicant for AWB [redacted]
(b.) Date of last consultation 5/95
(c.) Reason for consultation and diagnosis, treatment and advice. [redacted]

Complete if Principal Proposed Insured is a Dependent Spouse or a Minor

6. If Principal Proposed Insured is a Dependent Spouse
(a.) Name of Proposed Insured's Spouse Age Income
(b.) Total amount of Life Insurance in force on Proposed Insured's Spouse $
In which companies:
(c.) Is separate application being concurrently submitted on Proposed Insured's Spouse? Yes ☐ No ☐
If Yes, give details

7. If Dependent or Partly Dependent Minor, including College Students
State total life insurance on other family members (See Rate Manual for insurance requirements on head of family):

(Father)	Amount In Force—Applied for	(Brothers)	Age	Amount In Force—Applied for
(Mother)		(Sisters)		

1013488377 -10

DO NOT WRITE HERE

10134837 -9

MetLife

Metropolitan Life Insurance Company
New England Life Insurance and Annuity Company

10125245 5

Authorization and Acknowledgement Form

For underwriting and claim purposes, I permit:

—Any physician or other medical practitioner, hospital, clinic, other medically related facility, consumer reporting agency, or the Medical Information Bureau, Inc. (MIB) to give Metropolitan data of a medical nature. This data includes findings on medical care, psychiatric or psychological care or examination, or surgery that apply to me or to any of my children who are to be insured. I specifically authorize the disclosure to Metropolitan of any information concerning sexually transmitted diseases including venereal diseases, any Human Immunodeficiency Virus (HIV) test results, or information about Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, or confidential HIV-related information, and any information concerning a serious communicable disease, and any information concerning mental health. Also, any insurer may give Metropolitan medical data described above and data about current or pending coverage I may have with them.

—Metropolitan to get consumer reports, investigative consumer reports and motor vehicle reports about me or any of my children who are to be insured.

—Any employer, business associate, financial institution, insurer, government unit or MIB to give Metropolitan any data that they may have about the occupation, avocations, driving record, finances, character, general reputation and aviation activities of myself or my children to be insured.

I understand that:

—My medical records, including any alcohol or drug abuse data, may be protected by Federal Regulations—42 CFR Part 2. I permit Metropolitan to get any data for the reasons set forth above. I consent to the re-disclosure of such data as set forth on this form.

—Information concerning mental illness, HIV, AIDS, HIV-related illness and sexually transmitted or other serious communicable diseases may be controlled by various state or federal laws and regulations. I consent to the re-disclosure of such information as described in this form and as otherwise required or permitted by law.

—All or part of the data which Metropolitan gets may be sent to MIB. It may also be disclosed to and used by any Metropolitan reinsurer, employee, affiliate or contractor who performs any business service on any insurance I may have applied for or have with Metropolitan. If my application is declined or I am offered coverage in a substandard classification, Metropolitan may disclose all or part of the data to a substandard or declined risk broker or insurer that has obtained my written authorization to obtain such data.

—Information concerning myself, including HIV results, AIDS, HIV-related illnesses and serious communicable diseases may also affect the insurability of my spouse and children. To the extent Metropolitan may be considering applications on other family members, I consent to the use of such information to determine their insurability.

—I may ask to be interviewed if any investigative consumer report is obtained about me. Please get in touch with me between the hours of 09:00 AM and 04:00 PM. My phone number is (Area Code—Number) [redacted] (HOME)

My consent to get the data described in this form will end two years from the date shown below or for a shorter period if such period is prescribed by law. I may at any time, however, revoke my permission to get any data protected by 42 CFR Part 2 or any other federal or state law or regulation which provides for such revocation. Any action taken before revocation, however, will be valid.

I have been given Metropolitan's Consumer Privacy Notice. I know that I have a right to get a copy of this form. **A photocopy of this form is as valid as the original form.**

Witness

8/22/95
Date

LAMONT A. LOUDENSLAGER
Print Name of the Proposed Insured

x [signature]
Signature of the Proposed Insured (If Proposed Insured is under age 15, Signature of Parent, Guardian or Person liable for child's support)

KYM L. LOUDENSLAGER
Print name of the Proposed Insured's Spouse

Print Surname as it is on records if different from that signed above.

Signature of Applicant (If Applicant's Waiver of Premiums Benefit is requested)

x Kym L. Loudenslager
Signature of the Proposed Insured's Spouse (If insurance coverage is requested)

O36K-16-P-AUTH

SALES REPRESENTATIVE'S REPORT

The following information will be used in the evaluation of the application.

Note: When case is Nonmedical and Sales Representative is related to any person to be insured or is not authorized to write Nonmedical, Branch/District Management must (1) verify the answers to Part A and (2) complete and sign this report.

1. General Information

(a) Modal Premium [redacted]

Annualized Premium (Annual Mode Target Premium for Universal Life policies) [redacted]

Production Credit $ [redacted]

(b) In all cases where the annualized premium is more than $3,000 and the limited premium option is not elected, Form 15748 must be completed and submitted with the application. In such cases, check the box below.

☐ Form 15748 completed and attached to application

(c) For split commission cases involving two representatives, provide the information requested below indicating the percentage of commission applicable to each. (If more than two representatives are involved, complete Form 2824.)

	Print Name	Sign. No.	Br./Dist.	Agency/Index	Percent
1st Rep					00
2nd Rep					00

(d) Was a Personalized Sales Presentation (PSP) used in connection with this sale? Yes ☒ No ☐

(e) For VUL or [illegible] ... Yes ☐ No ☒

(f) Have you given to ... the ... Consumer Privacy Notice? Yes ☒ No ☐

2. If Medical Examination or Evaluation is Required

(a) Type Paramedical Medical Examiner ☐

(b) Place Place of Business Examiner's Office Residence ☐ Paramedical Facility ☐

(c) Appointment Date Time

3. Relationship to Proposed Insured(s)

(a) ☐ Relative by ... or ... Relationship

(b) Known { ☐ Well ☐ Slightly } for ___ years through { ... Business dealings ... Socially } ☒ Not known previously

4. Replacement

(a) Is this a replacement? Yes ☐ No ☒ If Yes, have you completed replacement forms? Yes ☐ No ☐ Not required ☒

(b) Is any part of the first premium to be paid by loan, cash value, or change in ... on Life Insurance in force in this or any other company? **If Yes, give details on page 2.** Yes ☐ No ☒

5. Certification and Signatures

(a) Did you see all of those to be insured on the date the application was written? Yes ☒ No ☐

If No, indicate on page 2 who was not seen and why. Give address, if other than that of principal Proposed Insured.

(b) Each question was asked of the persons to be insured and answered as recorded. All answers are correct to the best of my knowledge and belief.

Date 8/22/95 Signature and Title D- Alt

(c) To Be Completed by Sales Representative Where Required by State Law.

I certify that any required written disclosure statement was given to the applicant no later than the date this application was signed.

Date Signature

To be Completed by Branch Manager or District Sales Manager

1. Additional Policy

(a) Do you request issue of an additional policy? Yes ☐ No ☐ **If Yes, complete (b) and (c) below.**

(b) Amount $ Plan Optional Benefits

Note: The total amount requested will govern the medical and/or character requirements (which may differ from the requirements for the amount requested on Part A).

(c) Modal Premium $ Annualized Premium* $ Production Credit $

*For UL products, Annual Mode Target Premium

2. Review

Have you personally reviewed this application and the Purchaser's Rate ... if required? Yes ☐ No ☐

3. Signature

Has the Sales Representative's Report been completed by Branch/District Management? Yes ☐ No ☐

Date Signature and Title Not Required ☐

Branch/District No., Name and State	Dist. Office No., Name and State or Party ...	Agency Index ...	Last Name of Sales Representative (Print Firmly)	Title
C-11 Flint Hills		859-4	ALT	

10134837 -13

SUPPLEMENTAL INFORMATION

(If Juvenile Policy, obtain information on Proposed Insured from Parents)

Show all companies (including Canadian or Government, Fraternals, etc., for all persons to be insured

1. Details of Total Life Insurance In Force

Name	Company (If Met, give policy number)	Amount	Plan	Year of Issue	Check if Bus. Ins
LOMONT LOUDENSLAGER	MINNYARD'S LIFE	[redacted]	UL, ~~[illegible]~~	90	☐
LOMONT LOUDENSLAGER	OLD LINE LIFE		UL	90	☐
KYIM L. LOUDENSLAGER	OLD LINE LIFE		UL	90	☐
KALOE LOUDENSLAGER	OLD LINE LIFE		TERM	90	☐
					☐
					☐

Total Accidental Death Benefit in force on each person—give names and amounts, and indicate whether business or personal.

2. Financial Information

☒ Statement of Proposed Insured(s) ☐ Sales Representative's estimate

	Annual Earned Income	Income from Other Sources Amount	Source	Personal Net Worth—complete for insurance amounts of $100,000 or more
Proposed Insured	[redacted]			
Spouse or Applicant for AWB				

Premiums will be paid by: ☒ Proposed Insured ☐ Other—Name

Relationship to Proposed Insured — Estimated annual income of premium payer

3. Business Addresses

Print Proposed Insured's present and previous Business addresses. Give addresses for last 3 years if amount of insurance is $150,000 or less; for 5 years if $150,001 to $499,999, for 10 years if $500,000 or more. If more space is required, use Page 2

	Employer	Street and Number	City or Town	State and Zip Code	From Mo.	From Yr.	To Mo.	To Yr.
Proposed Insured	FIRST BAPTIST	[redacted]						
Spouse or Applicant for AWB								

4. Residence Addresses

Print Proposed Insured's present and previous Residence Addresses. Give addresses for last 3 years if amount of insurance is $150,000 or less; for 5 years if $150,001 to $499,999, for 10 years if $500,000 or more. Also give this information for others to be insured if different from Proposed Insured. If more space is required, use Page 2.

	Street and Number (If R.D., state number) Apt. No. or Floor	City or Town (If in country, give distance from and name of trading town and nearest post office)	State and Zip Code	From Mo.	From Yr.	To Mo.	To Yr.
Proposed Insured	[redacted]						
Spouse or Applicant for AWB							

5. Previous Name

Give previous name for any change of name within last 5 years (applies to any person to be insured).

6. Telephone Numbers

	Number	Most convenient time for call	Most convenient place to call
Proposed Insured	[redacted]	09:00 AM - 04:00 PM	CHURCH
Spouse or Applicant for AWB			

Our Local Office Is Located At:
FILE COPY
DISTRICT # : Cl[illegible] 3
CASE NUMBER: 195274873
UNDERWRITER: SHELLY ERICKSON

MetLife

MINISTERS LIFE, A MUTUAL CO
P O BOX 910
MINNEAPOLIS, MN. 55440

INSURED:
Lamont Loudenslager
[redacted]
DOB: [redacted]/54
POLICY : L6988776

Gentlemen:

We have received an application which indicates that insurance inforce in your company may be lapsed, borrowed against or otherwise so affected as to be considered a replacement.

We are giving you this information as you may wish to bring to your policyholder's attention any reasons why, in his or her interest, your policy should be continued inforce.

A Notice Regarding Proposed Replacement of Life Insurance or Annuity will be forwarded to you when received.

Sincerely yours,

Cynthia Schmadeke

Cynthia Schmadeke, Director
New Business Sales Support
Mid-America Head Office

September 20, 1995

FILE COPY

MetLife

[ ] Metropolitan Life Insurance Company
[ ] Metropolitan Insurance and Annuity Company
[ ] Metropolitan Tower Life Insurance Company
(X-Company for New App.)

Central Head Office
12902 East 51st Street
P.O. Box 500, Tulsa, OK 74121
(918) 252-8698

Important Notice Regarding Replacement of Life Insurance Or An Annuity

(To be used where the existing and proposed contracts are written by different companies).

Our agent is recommending to you that you purchase Life Insurance or an Annuity from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing contract issued by another insurance company or that you may obtain a loan from that company against your contract to make payments on the proposed contract. Any of these actions is replacement. This notice must be given to you. Please read it carefully.

Whether it is to your advantage to replace your existing contract, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present contract becomes final so that you may understand the essential features of the proposed and existing contracts.

To this end, we are required to notify the insurance company that issued your existing contract. That company may then furnish you additional information concerning your existing contract. You may want to contact that company or its agent for further information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision. If life insurance is involved, we are also required to give you a Policy Summary including complete information on the proposed policy no later than when that policy is delivered to you.

If either the proposed contract or the existing contract you intend to replace is participating, you should be aware that dividends may materially reduce the cost of the contract and are an important factor to consider. Dividends, however, are not guaranteed.

In the case of life insurance, you should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which our company could contest the policy because of a material misstatement or omission on your application, (or deny coverage, for death caused by suicide), may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy.

On the other hand, the proposed contract may offer advantages which are more important to you.

If you are considering borrowing against, or withdrawing funds from, your existing contract to pay for the proposed contract, you should understand that the amount of unpaid loan, including unpaid interest, or withdrawal, including any charges, will be deducted from the benefits of your existing contract.

After we have received your application and notified the other insurance company you will have twenty days from the date the proposed contract is delivered to you to cancel it and receive back all payments you made to us.

Caution

If, after studying the information made available to you, you decide to replace the existing contract with our company with a new contract, you are urged not to take action to terminate or alter your existing contract until after you have been issued the new contract, examined it and have found it to be acceptable to you. In the case of life insurance, if you should terminate or otherwise materially alter your existing coverage and fail to qualify for the new life insurance, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

I have received and read a copy of this Replacement Notice.

Applicant _____ Date _____

11586-A-KS (0991) Printed in U.S.A.
180000038658 (0991)

*or application or receipt number

Head Office Copy

180000038658 (0991) *or application or receipt number Head Office Copy

Our Local Office Is Located At:
FILE COPY
DISTRICT # : C11
CASE NUMBER: 195274873
UNDERWRITER: SHELLY ERICKSON

MetLife®

OLD LINE LIFE INS CO OF AMER
P O BOX 401
MILWAUKEE, WI. 53201

INSURED:
Lamont Loudenslager
[redacted]
DOB: [redacted]/54
POLICY : 1650010L

Gentlemen:

We have received an application which indicates that insurance inforce in your company may be lapsed, borrowed against or otherwise so affected as to be considered a replacement.

We are giving you this information as you may wish to bring to your policyholder's attention any reasons why, in his or her interest, your policy should be continued inforce.

A Notice Regarding Proposed Replacement of Life Insurance or Annuity will be forwarded to you when received.

Sincerely yours,

Cynthia Schmadeke

Cynthia Schmadeke, Director
New Business Sales Support
Mid-America Head Office

September 20, 1995

FILE COPY

CAAADW FAM (6/91)

Shelley

TELEPHONE INTERVIEW REQUEST FORM P

1312470J5 U

HEAD OFFICE: M UNDERWRITER ID: CASE #: 195-274-873
REQUEST NUMBER: 01 REQUEST DATE: 08/25/95 PRINT DATE: 08/25/95
AGENT NAME: DONALD ALT R71 D/A/1:C11-859-4

\##

PLEASE CALL: LAMONT LOUDENSLAGER
PLACE: H TIME: 09 AM - 04 PM HOME: [redacted] BUS: [redacted]
Luzc ↑
APPLICANT: LAMONT LOUDENSLAGER
AGE: 41 DOB: [redacted]/54 SEX: M SS#: [redacted]4347 MAR STAT: M
RES ADDR: [redacted] LANG: ENGLISH
[redacted]

HEIGHT: 5 FT 10 IN WEIGHT: 165 LB RELATIONSHIP TO OWNER: 1
DR LIC #: ST:
JOB TITLE: PASTOR EMPLOYER: FIRST BAPTIST
PHYSICIAN: DENNIS KEPKA FAMILY PRA ADDR: ELLSWORTH COUNTY HOSPITA
CITY: ELLSWORTH ST: KS UNDERWRITING AMT: 100000

comp

*** TELEPHONE INTERVIEWER RECORD ***

CALLERS INITIALS	NO ANSWER (DATE)	INCOMPLETE INTERVIEW (DATE)	DATE RETURNED TO UNDERWRITER NO COMPLT. INT.	DATE INT. COMPLT.	LENGTH OF CALL
KR 8/28 1.25 - home # is wrong				(0)	4 ?
KR 8/28 1.36 N/A					
KR 8/28 4.15 tried dialing [redacted]					N/A
went 9940l					
KR 9/5 10:35					

5312

INTERVIEW CONDUCTED WITH: (X) PROPOSED INSURED ( ) SPOUSE
( ) OTHER: ....
INTERVIEWEES RXN TO CALL: (X) FAVORABLE ( ) UNFAVORABLE ( ) NEUTRAL

COMPLETE THE FOLLOWING FORMS:
(X) GENERAL FORM
( ) MEDICAL FORM - ( ) A ( ) B ( ) C ( ) D
( ) FINANCIAL FORM - ( ) A ( ) B ( ) C
( ) AVIATION FORM - ( ) A ( ) B ( ) C
( ) AVOCATION FORM - RE:
( ) SUPPLEMENTARY QUEST. - NUMBERS:
( ) OCCUPATION FORM - NUMBERS:
( ) JUVENILE FORM - AWB REQUESTED
ADDITIONAL INSTRUCTIONS

MetLife 10123294[illegible]

☐ Metropolitan Life Insurance Company
☐ Metropolitan Insurance and Annuity Company
☐ Metropolitan Tower Life Insurance Company
(X Company for New App.)

Central Head Office
12902 East 51st Street
P.O. Box 500, Tulsa, OK 74121
(918) 252-8638

Important Notice Regarding Replacement of Life Insurance Or An Annuity

(To be used where the existing and proposed contracts are written by different companies).

Our agent is recommending to you that you purchase Life Insurance or an Annuity from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing contract issued by another insurance company or that you may obtain a loan from that company against your contract to make payments on the proposed contract. Any of these actions is replacement. This notice must be given to you. Please read it carefully.

Whether it is to your advantage to replace your existing contract, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present contract becomes final so that you may understand the essential features of the proposed and existing contracts.

To this end, we are required to notify the insurance company that issued your existing contract. That company may then furnish you additional information concerning your existing contract. You may want to contact that company or its agent for further information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision. If life insurance is involved, we are also required to give you a Policy Summary including complete information on the proposed policy no later than when that policy is delivered to you.

If either the proposed contract or the existing contract you intend to replace is participating, you should be aware that dividends may materially reduce the cost of the contract and are an important factor to consider. Dividends, however, are not guaranteed.

In the case of life insurance, you should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which our company could contest the policy because of a material misstatement or omission on your application, (or deny coverage, for death caused by suicide), may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy.

On the other hand, the proposed contract may offer advantages which are more important to you.

If you are considering borrowing against, or withdrawing funds from, your existing contract to pay for the proposed contract, you should understand that the amount of unpaid loan, including unpaid interest, or withdrawal, including any charges, will be deducted from the benefits of your existing contract.

After we have received your application and notified the other insurance company you will have twenty days from the date the proposed contract is delivered to you to cancel it and receive back all payments you made to us.

Caution

If, after studying the information made available to you, you decide to replace the existing contract with our company with a new contract, you are urged not to take action to terminate or alter your existing contract until after you have been issued the new contract, examined it and have found it to be acceptable to you. In the case of life insurance, if you should terminate or otherwise materially alter your existing coverage and fail to qualify for the new life insurance, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

I have received and read a copy of this Replacement Notice.

Applicant _____ Date _____

11886-A-KS (0991) Printed in U.S.A.
18000038658 (0991)

*or application or receipt number

Head Office Copy

MetLife

[X] Metropolitan Life Insurance Company
[ ] Metropolitan Insurance and Annuity Company
[ ] Metropolitan Tower Life Insurance Company
(X-Company for New App.)

Central Head Office
12902 East 71st Street
P.O. Box 500, Tulsa, OK 74121
(918) 252-8638

Important Notice Regarding Replacement of Life Insurance Or An Annuity

(To be used where the existing and proposed contracts are written by different companies).

Our agent is recommending to you that you purchase Life Insurance or an Annuity from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing contract issued by another insurance company or that you may obtain a loan from that company against your contract to make payments on the proposed contract. Any of these actions is replacement. This notice must be given to you. Please read it carefully.

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To this end, we are required to notify the insurance company that issued your existing contract. That company may then furnish you additional information concerning your existing contract. You may want to contact that company or its agent for further information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision. If life insurance is involved, we are also required to give you a Policy Summary including complete information on the proposed policy no later than when that policy is delivered to you.

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After we have received your application and notified the other insurance company you will have twenty days from the date the proposed contract is delivered to you to cancel it and receive back all payments you made to us.

Caution

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The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

I have received and read a copy of this Replacement Notice.

Applicant _____ Date _____

(1886-A-KS (0991) Printed in U.S.A.
18000038658 (0991)

*or application or receipt number

Head Office Copy

Name of Insured/Annuitant/Applicant
LAMONT LOUDENSLAGER

Application Number
[illegible]

Agency
859

Date of this Form
10/02/95

District/Branch
C11

Policy/Contract Number
958 201 834 UM

CASE # - 195 274 873

Application Amendment

To ☒ Metropolitan Life Insurance Company:
☐ Metropolitan Insurance and Annuity Company:
☐ Metropolitan Tower Life Insurance Company:

MetLife

I amend the application referred to above, as follows:

DO NOT ALTER OR AMEND THIS FORM (SEE INSTRUCTIONS)

AMEND SURNAMES ON PAGE 7 TO LOUDENSLAGER
AMEND 11E TO YES-WIFE KYM HAD APPENDIX OUT IN 2ND GRADE

This application amendment is part of the application referred to above and is subject to the agreements in that application. The application and this amendment are part of the policy/contract to which they are attached.
To the best of my knowledge and belief, the statements and answers in the application as amended by this form are true and complete as of the date this form is signed. There are no facts or circumstances which would require a change in the answers in the application, except as shown above.

Witness (Licensed Resident Agent)	Place	Mo. Day. Yr.	Signature
Witness to Signature (A)			(A) Insured/Annuitant/Applicant
Witness to Signature (B)			(B) Spouse (if Spouse signed application)
Witness to Signatures in (C) or (D)			(C) Owner (if other than (A) above)

If Owner is a firm, corporation or trust, enter full name on line (C) and have one or more partners, officers or trustees sign on line (D), and give their titles.

(D) _____

Return signed forms to MID-AMERICA Head Office/Home Office
New Business Processing Center Unit

FILE COPY

Metropolitan Life Insurance Company
P.O. Box 2003
Aurora, IL 60507-2003

MetLife

Lamont Loudenslager
[redacted]

11/03/95

Dear Lamont Loudenslager

Thank you for giving us the opportunity to provide for your insurance needs. If you have any questions concerning this policy please feel free to contact your branch office at 913-234-1505.

Please take a moment to read the attached Notice Of Free Look Right. It contains important information concerning your rights with regard to your policy.

Again, thanks for placing your confidence in the MetLife family. We hope to continue to meet your financial service needs.

MidAmerica Head Office
New Business Sales Support

Metropolitan Life Insurance Company
P.O. Box 2003
Aurora, IL 60507-2003

MetLife

19125245 b

Lamont Loudenslager
[redacted]

Date of Mailing: 11/03/95
Policy Number: 958 201 834 UM
Insured: Lamont Loudenslager
Plan: **Flexible Premium Multifunded Life Insurance**

Premium Mode: CHECK-O-MATIC
Planned Premium Payment: [redacted]

Notice of Free Look Right

We are sending you this notice to comply with the laws administered by the Securities and Exchange Commission. Please read this notice and keep it with your records.

You recently purchased a Flexible Premium Multifunded Life Insurance Policy from us. The policy's cash value will vary with the investment experience of the investment divisions of MetLife Separate Account UL to which amounts are allocated and the fixed rates of interest earned by allocations to the General Account, as discussed in the policy. Please examine your policy. You have the right to surrender the policy without charge and return it and receive a full refund of all premiums paid (Free Look Right). The deadline for exercising this Free Look Right is the latest of:

* 10 days after you received the Policy (except where state law requires a longer period for replacement policies);
* 45 days from the date you completed Part A of the application; or
* 10 days from the date of the postmark of the mailing of this notice.

If the policy is returned, we will treat it as if it were never issued, and we will promptly refund any premium paid.

In determining whether or not to exercise your Free Look Right, you should consider, among other things, the projected cost of your policy and your ability to make any additional premium payments required to keep the policy in force in the event the cash value of the policy (less indebtedness) is insufficient to pay the monthly deductions as they come due. The policy describes the circumstances under which the policy will terminate.

You also received a Prospectus describing the deductions from premiums before amounts are allocated to Separate Account UL and/or the General Account of MetLife, the monthly deductions from the policy's cash value, and the charges against the Separate Account. Total premium expense charges of 5.50% are deducted from all premium payments. These charges consist of a sales charge of 2%, a federal tax recovery charge of 1.50% and a state premium tax charge of 2%. In addition the policy's cash value will be reduced by a monthly deduction equal to the sum of:

* a monthly cost of term insurance charge;
* the cost of any optional insurance benefits added by the rider;
* during the first year a base administrative charge ranging from $5.00 to $20.00 amount of the policy based on age; thereafter a base administration charge ranging from $5.00 to $9.00 based on the specified face amount of the policy.
* during the first year, a monthly administrative charge equal to $.25 per thousand dollars of specified face amount.

Any request by a policy owner that results in an increase in the death benefit will result in a one-time expense charge of $5.00 per thousand dollars of increase. The monthly deduction will vary in amount from month to month.

At present, there is no transfer fee charged against the cash value of the policy for transfers among the separate accounts. The company, however, reserves the right in the future to assess a charge of up to $25.00 against each transfer.

If the policy is cash surrendered within the first fifteen policy years a surrender charge will be deducted. The surrender charge will be based on a charge per thousand of the specified rate amount, the death benefit option and age of the insured at issue or at the time of an increase in the specified face amount, which declines over the fifteen policy years to zero after the fifteenth year.

In addition, a daily charge equivalent to an effective annual rate of .90% of the average daily net asset value of each investment division of Separate Account UL will be deducted from the Separate Account for certain mortality and expense risks.

If you decide to surrender your policy, under the Free Look Right, complete the attached form. Return the form and your policy according to the instructions on the form. The returned form must be postmarked on or before the deadline described above.

Metropolitan Life Insurance Company

Joseph A. Reali
Vice-President and Secretary

Metropolitan Life Insurance Company
P.O. Box 2003
Aurora, IL 60507-2003

MetLife

Date of Mailing: 11/03/95

Policy Number: 958 201 834 UM

Lamont Loudenslager
[redacted]

Insured: Lamont Loudenslager

Plan: **Flexible Premium Multifunded Life Insurance**

Premium Mode: CHECK-O-MATIC

Planned Premium Payment: [redacted]

Request for Return of Premiums Paid

Instructions
Please Read Carefully

If, after reading the enclosed notice, you elect to return your policy under the Free Look Right, you must:

1. Sign and date the attached form.
2. Mail this form together with your policy (if received by you) to:

   MetLife
   P.O. Box 2003
   Aurora, IL 60507

3. The postmark on the return envelope must be on or before the last date permitted under the Free Look Right, as described in this notice.
4. Check the box on the bottom if you have not yet received your policy at the time of mailing this form.

To be Filled Out by Owner

Request for Return of Premiums Paid

To: Metropolitan Life Insurance Company

Pursuant to the terms of the notice previously furnished me by **MetLife**, I hereby return this policy numbered above (the "policy") for surrender and request a full refund of the premium paid by me for the policy. I hereby release **MetLife** from any and all claims arising out of or in connection with the sale or issuance of the policy and I hereby acknowledge that **MetLife's** sole liability with respect to the policy is the refund to me of the premium paid for the policy.

Date _____ Signature of Policy Owner _____

Check box if applicable

☐ I have not yet received the policy and should it be received, I will return it to MetLife.

TELEPHONE INTERVIEW OF PROPOSED INSURED

INTERVIEW FORM - GENERAL

1. I see that your residence address is: [redacted]

a. Is this correct? YES / NO
(If not, please write correct residence address here: _____

b. Is your residence address the same as your mailing address? YES / NO

(If not, please write correct mailing address here: _____

2. In what state did you sign the application? KS

3. Did your agent analyze your Life Insurance holdings, your Social Security, and your other financial assets in order to suggest a definite Life Insurance program to fit your needs? YES / NO

4. For what purpose or purposes did you buy Life Insurance from MetLife? (mark all that apply)

- __ to cover burial and other final expenses
- [X] to help provide for your family's needs after your death
- __ as a way of helping to save money for retirement
- __ as a way of helping to save money for your children's educational expenses
- __ to provide money to pay off a mortgage after your death
- __ for business purposes (e.g. key person, split dollar, partnership, stock redemption, etc.)
- __ for estate liquidity (e.g. to offset estate taxes, to cover probate expenses, etc.)
- __ for tax sheltered savings as a charitable contribution

10/25/2016 19

5. I see that you work for First Baptist
*(If employed in Hotel or Restaurant business, complete **SUPPLEMENTAL QUESTIONS 28 - 30**, regarding bartending duties; If disabled, complete **FINANCIAL FORM C - UNEMPLOYMENT** and **MEDICAL FORM**, or provide specific details in health questions.)*

How long have you been employed there? Jan 98

6. Are you now actively at work there? yes
*(If laid-off, etc., complete **FINANCIAL FORM C - UNEMPLOYMENT**)*

7. Have you flown as a pilot, student pilot, or crew member in the last 2 years? [redacted] *(If yes, complete **AVIATION FORM.**)*

8. Have you ever engaged in any hazardous sport or hobby such as auto racing or scuba diving? [redacted] *(If yes, complete appropriate **AVOCATION FORM**, either for **SCUBA DIVING**, or for any other Avocation.)*

9a. Have you had your driving license suspended or revoked in the last three years? [redacted]

b. Have you been convicted of three or more moving violations in the last three years? [redacted]

If yes: Date(s)_____

Type of violation _____

Drivers license number _____ State _____

10. Have you ever been convicted of driving while intoxicated or impaired? [redacted]
*(If yes, complete Supplemental **ALCOHOL QUESTIONS 34 + 35.**)*

If yes: Date(s)_____

Details _____
(i.e., was license suspended? accident involved? etc.)

Drivers license number _____ State _____

11. Have you ever used:

Cigarettes [redacted] Date last used:_____
Cigars Date last used:_____
Pipe Date last used:_____
Smokeless Tobacco Date last used:_____

11a. How tall are you? 5'10"

b. How much do you weigh? 165lbs

12. Do you drink alcoholic beverages? [redacted]

If yes:
How often? _____

What do you usually drink? _____

About how many drinks on each occasion? _____

Has your use of alcohol changed? _____

What did you used to drink? _____

How often did you do this? _____

When did you change your use of alcoholic beverages? _____

If no:
Have you ever drank alcoholic beverages? [redacted]

What did you drink? _____

How often? _____

How many on each occasion? _____

When did you discontinue using alcoholic beverages? N/A

13. Have you ever been told by a doctor to stop drinking? [redacted]
*(If yes, complete Supplemental **ALCOHOL QUESTIONS 34 + 35.**)*

14. Have you ever used any drugs such as marijuana, cocaine, heroin, or barbiturates? [redacted] If yes, What? _____
*(If yes to any, complete Supplemental **ALCOHOL QUESTIONS 34 + 35.**)*

(If yes to marijuana, ask how many marijuana cigarettes do/did they use on each occasion _____.)

How often? _____ When was the last time? _____

If age 40 or older: MEDICAL QUESTIONS:

15. What is the name of your personal physician, practitioner, or health care facility? [redacted]

16. When was the last time you went to this physician, practitioner, or health care facility? [redacted]

Why did you go? [redacted]

What was the diagnosis? _____

(if client gives a history of HEART TROUBLE, HIGH BLOOD PRESSURE, CANCER, TUMOR, DIABETES, please complete appropriate Supplemental ***MEDICAL FORM.)***

17. Have you had any other medical problem which required treatment, medical attention or advise from any physician, or health facility? [redacted]

If yes, Name of Doctor: _____

Date seen: _____

Symptoms: _____

Diagnosis: _____

Regarding Replacement:

18. What source or sources of money are you using to pay the premium for the Life Insurance you recently purchased? (mark all that apply)

X Current Income
__ Savings
__ money that has built up in another Life Insurance policy I still have
__ other

19. In connection with this application, do you intend to discontinue any existing insurance you currently have? yes.

If yes, name of company being replaced: Old line life & ministers [redacted] life

Also, is this life insurance, group insurance, or health insurance? _____

Is this insurance on your life or on another family member? _____

old line life [redacted] on wife
[redacted] on daughter
[redacted] on him
ministers - on him [redacted]

101348377 -2

SUPPLEMENTARY INFORMATION from Sales Representative

101348377 -1

101252045 22

MetLife®

Metropolitan Life Insurance Company | Metropolitan Insurance and Annuity Company

Application for Life Insurance

Instructions

- Complete the application in black ink. Print all answers legibly.
- For "Yes" answers to questions 12.(g.) and 12.(h.), complete Form O36K-16-AVIA and/or Form O36K-16-AVOC.
- If insurance is for business purposes, complete Business Insurance Supplement Form O36K-16-BIS

Advance Payment Coupon

Dst. No.: 011

Agcy. No.: 854

Company:
- ✓ Met Life
- MIAC
- Tower

*Enter Type of Business Code
1 PLI
2 PHI
3 UNASSIGNED
4 UNASSIGNED
5 EDP
6 Term Conversion
7 Reissue
8 Other

1537312

**Enter type of product (i.e., UL (Universal Life), FPVUL (UL II), SPVL, VLI (Variable Life) and OTHER (Other Products))

Proposed Insured or Annuitant (Employer's Name)—Last & First†: [illegible]

Applicant's Name—Last & First†:

Date D72 Completed: 08/25/95

Application Date: 08/29/95

† See Reverse Side

Completed By: [illegible signature]

Sub Prod	Ck. Id	Amount
H.O. Use.	H.O. Use.	[redacted]

Date Received

H.O. Use

This copy is to be attached to the application (or Forms 0106 for Term Conversions) prior to submission to the H.O.

The amount of this coupon should agree with the amount of the advance payment indicated on the application.

Date Credited: Signature

O36K-16

For Home Office Use Only

131232385 23

[X] METROPOLITAN LIFE INSURANCE COMPANY

[ ] METROPOLITAN INSURANCE AND ANNUITY COMPANY

[ ] METROPOLITAN TOWER LIFE INSURANCE COMPANY

Supplement to Part A, Application for Life Insurance Dated 8/22, 19 95
In connection with the issue of the policy applied for, have you replaced or is it your intention to replace any of your existing policies by:

1. Stopping premium payments or cash surrendering? Yes [ ] No [X]
2. Changing your policy(ies) in any way? (If Yes, give details below.) Yes [ ] No [X]
3. Borrowing in a single sum or setting up a systematic schedule of borrowing? (If Yes, give details below.) Yes [ ] No [X]

Policy Number(s)			
Plan of Insurance			
Amount of Insurance Basic			
Riders (Term)			
Date of Issue			
Company			

Details:

AGREEMENT

All statements and answers in this application supplement are true and complete to the best of my knowledge and belief. It is agreed that such statements and answers will be part of Part A of the application.

Witness (Licensed Resident Agent)	Place	Mo./Day/Yr.	Signature
[signature] Witness to Signature in (A)	Lorraine, ND	8/22/95	[signature] (A) Proposed Insured
Witness to Signature in (B)			(B) Owner (If other than Proposed Insured)

MetLife®

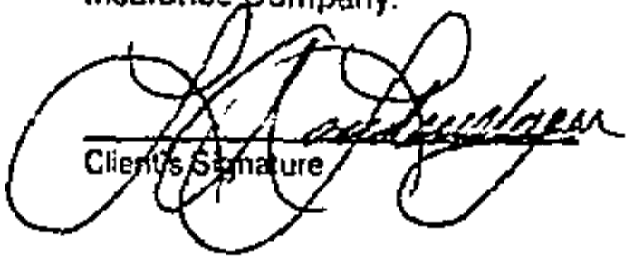
APPLICATION NO. 101348377

CASE NO. _____

Metropolitan Life Insurance Company

RE Life Insurance Buyer's Guide

This will acknowledge that I have received a copy of the **Life Insurance Buyer's Guide** from Metropolitan Life Insurance Company.



Client's Signature 8/22/15 Date

ALT Acct. Representative's Name 8/22/15 Date

L. A. LOUDENSLAGER Client's Name (Please Print)

Br. No. C-11 Name FLINT HILLS

Agency No. 859 Index 4

18000109681 (0394) (BG-ACK)

NOTE: The Sales Office must staple this sheet to the related application before submitting to the Home Office.

SONIC CASE SUMMARY

POLICY/CASE NO : 1952749[illegible] DATE TRANSMITTED : 08/24/95 REG/DIST : R71/C11
PART A : 08/22/95 PLAN : FPML MODAL/PLANNED PREMIUM: [redacted]
MODE : C FACE AMT: $100,000 TOTAL INSURANCE: $100,000
INS NAME : LAMONT LOUDENSLAGER DOB: [redacted]/54
AGE : 41 SSN : [redacted]-4347 CLASS : AIF/MIB :

RIDERS : DW : N SP TERM $ CH TERM $ 5000 ADB : N TI : CV : N
COL : N SSR : N GI $ LT : YRS $ AWB : N LTC : N
PUAR: N ACOB : N 4YT $ SIB $ IBSR : YRS $
FTD : YRS $ GRR : AIB : $

SPO/APP NAME : KYM LOUDENSLAGER DOB : [redacted]/57
AGE : 30 SSN : [redacted]-9352 CLASS : AIF/MIB :

SALES REPRESENTATIVES :

1) DIST : C11	AGY : 359	IDX : 4	%100
2) DIST :	AGY :	IDX :	%
3) DIST :	AGY :	IDX :	%
4) DIST :	AGY :	IDX :	%
5) DIST :	AGY :	IDX :	%

CHECK-O-MATIC
DEP NAME : KYM L. LOUDENSLAGER
BILL DAY : 22 TRANSIT : 101109237 ACCT NO : /109177

MetLife

MetLife®
Metropolitan Life Insurance Company

Application No. 101348377

Flexible Premium Multifunded Life Insurance Policy
Customer Profile Form

1. **Proposed Insured** LAMONT A. SHOUDENSLAGER
Full Name First Middle Initial Last

2. **Main Investment Objective**
☐ Preservation of Capital ☐ Growth ☐ Growth and Income
☐ Income ☒ Aggressive Growth

3. **Financial Information**
a) Owner's Annual Income $ [redacted]
b) Owner's Net Savings and Investments (not including personal residence, home furnishings or personal automobiles)
[redacted]

4. **Systematic Transfer Options** ☐ Yes ☐ No
(Select no more than one)

☐ **Equity Generator**—In each policy month that at least $20 is earned as interest in the Fixed Account, interest earned that month will be transferred to the Stock Index Investment Division.

☐ **Equalizer**—At the beginning of each policy month, the amount in the Fixed Account will be balanced with the amount in the Stock Index Investment Division. A transfer will be made from one Division to the other, so that the amounts in both Divisions are equal.

☐ **Allocator**—Each policy month, funds will be transfered from the Money Market Investment Division to the Fixed Account or to any Investment Division specified by the policyowner below:

1. ☐ As long as possible:
Transfer $ ________ per month to Fixed Account
Transfer $ ________ per month to ________________ Division
Transfer $ ________ per month to ________________ Division

2. ☐ Transfer $ ________ per month for ______ months to Fixed Account
Transfer $ ________ per month for ______ months to ________________ Division
Transfer $ ________ per month for ______ months to ________________ Division

3. ☐ Transfer a total of $ ________ over ______ months to the:
☐ Fixed Account ☐ Growth ☐ Diversified
☐ Income ☐ International Stock
☐ Stock Index ☐ Aggressive Growth

L. Shoudenslager
Signature of Proposed Insured or Owner if Named in Item 6 of Part A

8/22/95
Date

MetLife

Supplement II to Part A

Application No. 101348577
Case No.

[redacted] ☐ Metropolitan Life Insurance Company
☐ Metropolitan Tower Life Insurance Company

Flexible Premium Multifunded Life (FPML)

1. Investment Division/Account Allocation

Select the percentage of premium to be allocated to each division/account. For each division/account to which an allocation is made the percentage must be a whole number and must be at least 10% (Enter zero for any division/account to which no allocation is made). The percentage will apply to future premiums unless changed by the owner.

Division/Account	Allocation
Growth	%
Income	[redacted]%
Money Market	%
Diversified	%
Aggressive Growth	[redacted]%
International Stock	%
Stock Index	[redacted]%
Fixed	%
Other (Specify)	%
	100%

2. Suitability

Applies to both Proposed Insured (Applicant for Juvenile policy) and Owner if Owner is other than Proposed Insured:

(a) Have you received a prospectus for the policy indicated above? Yes X No ☐
Edition date of Prospectus 5-1-95
Edition dates of any supplements 5-1-95

(b) Have you received a prospectus for the Metropolitan Series Fund? Yes X No ☐
Edition date of Prospectus 5-1-95
Edition dates of any supplements 5-1-95

(c) Do you understand that under the policy indicated above (exclusive of any optional benefits):
(i) the amount of death benefit in excess of the Specified Face Amount for FPML policies may increase or decrease depending on the policy's investment experience? Yes X No ☐
(ii) the duration of the death benefit for FPML policies may increase or decrease depending on the policy's investment experience? Yes X No ☐
(iii) the cash value may increase or decrease depending on the policy's investment experience? Yes X No ☐
With this in mind, do you believe that the policy indicated above is in accord with your insurance objectives and financial needs? Yes X No ☐

Note: upon request, we will furnish illustrations of benefits, including death benefits and cash values, for (a) the policy applied for and (b) a fixed benefit life insurance policy for the same premium.

It is understood that, as specified in 2.(c) above, the amount and/or the duration of the Death Benefit and the amount of the Cash Value may increase or decrease based on the investment experience of the applicable Separate Account and are not guaranteed.

WITNESS (Licensed Resident Agent)	PLACE (City/State where Signed)	Mo. Day Yr.	Signature
Witness to Signature in (A)	LORRAINE, KS	5/21/95	X (A) Proposed Insured (Age 15 or Over)
Witness to Signature in (B)			(B) Owner (if named in Part A)

If Owner is a firm or corporation, enter on line (B) full business name as it appears in Part A and have one or more partners or officers (other than Proposed Insured) sign on line (C), and give their titles.

(C) _____

Complete Only for a Juvenile Policy. Also, be sure to complete Owner Designation in Part A and have Owner sign in (B) above.

Witness to Signature in (D)			(D) Applicant (Juvenile Policy)
Witness to Signature in (E)			(E) Child (required only if a New York State resident and exact age is between 14½ and 15)

Also to be signed below if Applicant or Owner is not a parent, guardian or person liable for child's support. I consent to this application for insurance on the life of the Proposed Insured. I have read the answers in this application, and they are true and complete to the best of my knowledge and belief.

Witness to Signature in (F)			(F) Parent, Guardian or Person Liable for Child's Support

101348377 -11

MetLife

Metropolitan Life Insurance Company
Metropolitan Insurance and Annuity Company

Request for Check-O-Matic Arrangement

The Company checked above is requested and authorized to draw checks or share drafts, to issue directions to debit a bank account, or to initiate electronic fund transfer debits each month to pay the premiums due on a life insurance policy as described below. These premiums are to be charged against the account identified below.

(Note: If the Check-O-Matic Arrangement is Desired, Attach a Voided Blank Check or Draft to Ensure Accuracy)

The Check-O-Matic arrangement will apply to any insurance policy issued on the basis of an application dated 8/22 1995 in which application LOMONT LOUDENSLAGER is named as the Proposed Insured, or to any renewal of such policy. However, the Check-O-Matic arrangement will not take effect unless at the time of delivery of the policy [illegible] first monthly Check-O-Matic effect debits, as authorized according to the schedule initiated on or about The undersigned or the account pany upon If the policy ums and pay age may be If this arrangement pany under (including on the date in effect with period up to Please debit

REV. L. A. LOUDENSLAGER
KYM L. LOUDENSLAGER
[redacted]
0917
82-923
1011

1010 $ DOLLARS

LORRAINE STATE BANK
MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION
LORRAINE, KANSAS 67459

[redacted] 0917

the insured, by the Company anned premiums ance coverage the Company's miums ales in effect pany's rule, for any

Give policy or contract number of any other Company policies or contracts currently under the Check-O-Matic arrangement:

Authorization to Honor Checks, Share Drafts or Account Debits

Name of Depositor REV. L. A. LOUDENSLAGER
KYM L. LOUDENSLAGER
(Print as it appears on Banking Institution records) (Account or Code Number)

To LORRAINE STATE BANK
(Name of Banking Institution) (Branch)

LORRAINE, KS 67459
(Address of Banking Institution or Branch where account is maintained)

([redacted] (Transit No.)

As a convenience to me I authorize you to pay and charge to my account (a) checks, (b) share drafts, (c) electronic fund transfer debits or (d) other account debits made by, and payable to the order of the Company checked above.

I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason, you will not be under any liability even though dishonor results in the forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

Request and Authorization Signatures

Date 8/22/95

Signature of Proposed Insured (Owner) x Lomont Loudenslager

Date 8/22/95

Signature of Depositor x Lomont Loudenslager
(If Joint Account, other Depositor sign below)

Policy or Contract No.

Signature of Depositor x Kym L. Loudenslager

O36K-16 CK